EVALUATION OF THE CERTIFICATE OF NEED APPLICATION SUBMITTED BY MANOR CARE OF MEADOW PARK, INC. PROPOSING TO ESTABLISH A MEDICARE CERTIFIED/MEDICAID ELIGIBLE 120-BED SKILLED NURSING CENTER IN VANCOUVER TO SERVE THE RESIDENTS OF CLARK AND SKAMANIA COUNTIES.

PROJECT DESCRIPTION

Manor Care, Inc. is a Delaware Corporation with a principle place of business at 333 North Summit Street, in the city of Toledo, within the state of Ohio. It is not registered in Washington State, rather it is the parent company of four subsidiaries, one of which is registered in Washington.[1] [source: Business Risk Assessment Analysis, p2]

Heartland Employment Services

An Ohio corporation registered in the state of Washington. Heartland Employment Services is a direct employer of all corporate and support employees. The corporation does not own or operate any health care facilities; however, a branch of this entity owns and operates home care agencies throughout the United States.

HCRC, Inc.

A Delaware corporation that is not registered in Washington State. HCRC, Inc. is a subsidiary of Heartland Employment Services and the parent company of Health Care and Retirement Corporation of America, which is the direct owner and operator of a number skilled nursing facilities and the parent of subsidiaries that own and operate nursing home facilities.

MNR Finance Corporation

Another Delaware corporation that is that is not registered in Washington State and does not own or operate any skilled nursing facilities.

Manor Care of America, Inc

Also a Delaware corporation not registered in Washington State and the parent corporation of Manor Care Health Services, Inc., another Delaware corporation. Manor Care Health Services, Inc. is the direct owner and operator of several skilled nursing facilities and the parent corporation of subsidiaries that own and operate nursing home facilities. Manor Care Health Services, Inc. is not registered in Washington State; however, it is the parent corporation of Manor Care of Meadow Park, Inc, which is registered in Washington.

As of the writing of this evaluation, Manor Care, Inc. is the second largest provider of long term services in the nation. Through its subsidiaries, Manor Care, Inc. owns, operates, or manages over 500 healthcare facilities, which includes skilled nursing centers, assisted living facilities, outpatient rehabilitation clinics, and hospice and home health offices across the nation. For nursing homes and assisted living facilities alone, Manor Care owns or operates over 300 in 32 states through its subsidiaries. For Washington State, Manor Care, Inc. owns and operates four skilled nursing facilities through its Manor Care of Meadow Park subsidiary; and the Heartland subsidiary owns and operates a home care agency and a Medicare certified home health agency in the state. The Washington State facilities and city of location are shown in the chart on the following page. [source: November 3, 2004, supplemental information, pp1-2; Manor Care Website at www.hcr-manorcare.com]

[1] HCR ManorCare is the trade name used by the parent company, but it is not a legal entity.

Skilled Nursing Facilities	Home Care and Home Health Agencies
Manor Care of Gig Harbor, Gig Harbor	Heartland Home Care, Seattle
Manor Care Health Services, Lynnwood	Heartland Home Health Care Services, Seattle
Manor Care Health Services, Spokane	
Manor Care Health Services, Tacoma	

Manor Care of Meadow Park, Inc

Through its subsidiaries, the healthcare facilities owned, operated, or managed by Manor Care, Inc. are grouped geographically, rather than corporately, into seven operating divisions:

Mid-Atlantic Midwest Mid-States East **West** South Central

Washington State is located in the West division [in bold above], and includes facilities owned and operated by Manor Care Health Services, Inc. or its subsidiary, Manor Care of Meadow Park, Inc. This application was submitted by Manor Care of Meadow Park, Inc. [source: November 3, 2004, supplemental information, pp1-2] For Certificate of Need purposes, Manor Care of Meadow Park, Inc. is considered the applicant, and will be referenced in this document as "MCMP."

This project proposes to establish a 120 bed Medicare certified/Medicaid eligible SNF located at 14906 NE 20th Street, Salmon Creek within Clark County, to be known as Manor Care of Salmon Creek (MCSC). The planning area for this project is Clark and Skamania counties. The proposed SNF will contain 28 private rooms, 46 semi-private rooms, two nurses stations, physical therapy, occupational therapy, speech therapy, recreational therapy space, resident lounges, dining rooms, beauty/barber shop, a kitchen, administrative offices and support areas.

The anticipated date of commencement of the project is July 1, 2006, with an estimated date of completion as November 2007. Therefore, the first full year of operation is projected to be calendar/fiscal year 2008.

The estimated capital expenditure for this project is $11,924,000, of which 55% is related to constructions costs; 17% is related to land purchase; 13% is related to equipment costs; 7% is related to corporate overhead; 5% is related to state sales tax; and the remaining 3% is related to fees and real estate taxes. [source: November 3, 2004, supplemental information, Appendix 11]

APPLICABILITY OF CERTIFICATE OF NEED LAW

This project is subject to Certificate of Need review as the construction, development, or other establishment of a new health care facility under the provisions of Revised Code of Washington (RCW) 70.38.105(4)(a) and Washington Administrative Code (WAC) 246-310-020(1)(a) and 246-310-380.

APPLICATION CHRONOLOGY

July 20, 2004	Letter of Intent Received
August 31, 2004	Application Received
September 29, 2004 through December 15, 2004	Screening activities and responses
December 22, 2004	Department Begins Review of Application
February 8, 2004	Public Hearing Conducted

	End of Public Comment
February 25, 2005	Rebuttal Comments Due
April 11, 2005	Department's Anticipated Decision Date
December 9, 2005	Department's Decision Date

COMPARATIVE REVIEW AND AFFECTED PARTIES

As directed under WAC 246-310-130(5)(c), the department accepted this project under the nursing home current review cycle for Clark County. In accordance with CN Program policy, when applications initially submitted under a concurrent review cycle are deemed not to be competing, the department has converted the review to the regular review process. Given that this application was the only application received under the concurrent review cycle for Clark County, the application was converted to a regular review.

Throughout the review of this project, three entities sought and received affected person status under WAC 246-310-010. All of the entities are community based SNFs, located in Vancouver within Clark County.

- Prestige Care, Inc. owner/operator of Discovery Nursing & Rehab of Vancouver;
- Fort Vancouver Convalescent Center owner/operator of Fort Vancouver Convalescent Center; and
- Eagle Healthcare, Inc. owner/operator of Highland Terrace Nursing Center and Parkway North Care Center.

SOURCE INFORMATION REVIEWED

- HCR ManorCare's Certificate of Need Application received August 31, 2004
- HCR ManorCare's supplemental information received November 4, 2004, November 17, 2004, and December 15, 2004
- Public comment received during the course of the review and on February 8, 2005, at the public hearing.
- HCR ManorCare's Rebuttal comments received February 24, 2005
- Population data obtained from the Office Financial Management based on year 2000 census published January 2002.
- Data obtained from the US Census Bureau website http://quickfacts.census.gov
- Years 2003 and 2004 Medicaid cost report data provided by the Department of Social and Health Services
- Licensing and/or survey data provided by the Department of Social and Health Services
- Survey data obtained from the Centers for Medicare and Medicaid Services website http://www.medicare.gov/NHCompare/home.asp
- Data obtained for nursing homes, adult family homes, and boarding homes from DSHS website http://www.aasa.dshs.wa.gov
- Certificate of Need Historical files
- Business Risk Assessment review received June 22, 2005, from the Department of Social and Health Services' Office of Financial Recovery
- Information obtained from the applicant's website at http://www.hcr-manorcare.com
- Certificate of Need Historical files
- Adult Family Home and Boarding Home Data obtained by The Gilmore Research Group received October 2005
- Revised Code of Washington 70.127 governing in-home service agencies

CRITERIA EVALUATION

To obtain Certificate of Need approval, the applicant must demonstrate compliance with the criteria found in WAC 246-310-210 (need); 246-310-220 (financial feasibility); 246-310-230 (structure and process of care); 246-310-240 (cost containment) and WAC 246-310-360 (nursing home bed need method).[2]

CONCLUSION

For the reasons stated in this evaluation, the application submitted by on behalf of Manor Care of Meadow Park is consistent with applicable criteria of the Certificate of Need Program, provided the applicant agrees to the following terms:

1. Prior to commencement of the project, Manor Care of America, Inc. shall provide to the department a copy of the Manor Care of Salmon Creek's final Admissions Agreement. This agreement must state that all services at this facility will be accessible to all persons without regard to race, color, ethnicity, sexual preference, disability, national origin, age or inability to pay.

2. Prior to commencing this project, the applicant must provide to the department for review and approval an executed copy of the purchase and sales agreement for the proposed site located at 14906 NE 20th Avenue, Salmon Creek.

3. Prior to providing services at Manor Care of Salmon Creek, the applicant will provide functional plans outlining the services to be provided through a national contract with Manor Care, Inc. and those that would be provided within the Clark and Skamania County planning area.

The approved capital expenditure associated with the establishment of a new, 120-bed skilled nursing facility in Clark County is $11,924,000.

[2] Each criterion contains certain sub-criteria. The following sub-criteria are not relevant to this project: WAC 246-310-210(3), (4), (5), and (6) and WAC 246-310-240(2) and (3).

A. Nursing Home Bed Need Method (WAC 246-310-360)

Based on the source information reviewed, the department determines that the application is consistent with the nursing home bed need methodology in WAC 246-310-360.

For all applications where the need for nursing home beds is not deemed met as identified in RCW 70.38.115(13), the [following] mathematical calculation will be used as a guideline and represent only one component of evaluating need.

As stated in the project description portion of this evaluation, the proposed SNF would be an additional facility in the Clark/Skamania planning area, and the 120 beds would be added to the planning area's total bed count. As such, the need for an additional 120 beds must be demonstrated by the applicant. One component of evaluating need for additional SNF beds within a county is applying the nursing home bed need numeric methodology. The ratio of 40 beds per 1,000 population over 65 years of age (40/1,000) is used for projecting total bed need for SNFs in the state and within a planning area.

The methodology, outlined in WAC 246-310-360, is a four-step process. The first step requires a computation of the statewide and planning area specific estimated bed need for the projection year.[3] The second step requires a computation of the projected current supply ratio statewide and for each planning area. The third step requires a determination of the planning areas that will be under the established ratio or over the established ratio in the projection year. The fourth, and final step, requires a comparison of the most recent statewide bed supply with the statewide estimated bed need.

Application of the first four steps of the methodology outlined above indicates that Washington State is projected to be under the 40/1,000 target ratio by 4,338 beds in year 2007—the projection year.

Step four provides further guidance if the current statewide bed supply is greater than or equal to the statewide estimated bed need, or if the current statewide bed supply is less than the statewide estimated bed need. Given that the current statewide bed supply is less than the statewide estimated bed need, the department must then determine the difference between the statewide estimated bed need and the statewide current bed supply, which is referenced as "statewide available beds." The methodology then requires a comparison of whether the "statewide available beds" is sufficient to allocate to each planning area under the establish 40/1,000 ratio enough beds to bring that planning area up to the established ratio. If there are not enough beds, the methodology directs the department to assign to each planning area under the established ratio a proportion of statewide available beds equal to the ratio of that planning area's bed need to reach the established ratio in the projection year. The proposed health planning area for this project is the combined area of Clark and Skamania Counties. Application of this portion of step four to this planning area indicates that 627 additional beds could be added to bring the planning area to the established ratio in the projection year.

To demonstrate need for an additional 120 beds within the planning area, MCMP provided calculations that conclude the planning area is currently under the 40/1,000 target ratio. While comments were provided by both affected and interested persons in opposition to this project, none of the comments dispute the methodology's mathematic conclusion of need for additional beds within Clark and Skamania counties. Utilization of this numeric methodology alone would justify an addition of beds to the planning area in the projection year 2007.

[3] For nursing homes applications submitted in the 2004 concurrent review cycle, 2007 is the projection year.

B. Need (WAC 246-310-210)

Based on the source information reviewed, the department determines that the application is consistent with the applicable need criteria in WAC 246-310-210.

(1) The population served or to be served has need for the project and other services and facilities of the type proposed are not or will not be sufficiently available or accessible to meet that need

WAC 246-310-210 requires the department to evaluate all CN applications on the basis of the population's need for the service and determine whether other services and facilities of the type proposed are not, or will not be, sufficiently available or accessible to meet that need. Additionally, subsection (6) identifies the process to be used to evaluate this sub-criterion. Specifically, if the state is below the statewide estimated bed need, the department shall determine the need for nursing home beds, including distinct part long-term care units located in a hospital licensed under chapter 70.41 RCW, based on the availability of:

1) other nursing home beds in the planning area to be served; and
2) other services in the planning area to be served. Other services to be considered include, but are not limited to: assisted living (as defined in chapter 74.39A RCW); boarding home (as defined in chapter 18.20 RCW); enhanced adult residential care (as defined in chapter 74.39A RCW); adult residential care (as defined in chapter 74.39A RCW); adult family homes (as defined in chapter 70.128 RCW); hospice, home health and home care (as defined in chapter 70.127 RCW); personal care services (as defined in chapter 74.09 RCW); and home and community services provided under the community options program entry system waiver (as referenced in chapter 74.39A RCW). The availability of other services shall be based on data which demonstrates that the other services are capable of adequately meeting the needs of the population proposed to be served by the applicant.

Services to be provided at MCSC include skilled nursing, rehabilitation, and a variety of therapies. [source: Application, p4] While the applicant asserts throughout its application that the community-based providers are not providing the same type of care that would be provided at MCSC, the department must consider their availability and determine whether patients could be better served in those settings.

Skilled Nursing Facilities—10 SNFs representing 977 beds

As of the writing of this evaluation, the Clark/Skamania planning area has 977 skilled nursing facility (SNF) beds distributed among ten community-based SNFs. Services provided at SNFs include skilled nursing services, including convalescent or chronic care, or both, for a period in excess of twenty-four consecutive hours. Convalescent and chronic care may include but not be limited to any or all procedures commonly employed in waiting on the sick, such as administration of medicines, preparation of special diets, giving of bedside nursing care, application of dressings and bandages, and carrying out of treatment prescribed by a duly licensed practitioner of the healing arts. It may also include care of mentally incompetent or acutely ill persons. [source: RCW 18.51]

Eligibility for Medicare and Medicaid skilled nursing facility services is governed by the Centers for Medicare and Medicaid Services (CMS). Medicare covers skilled nursing facility services for as long as a patient is eligible and the patient's physician orders the services. Eligibility requirements for coverage by Medicare includes a hospital stay for

three consecutive days prior to being admitted into the skilled nursing facility; further the skilled care must be required on a daily basis and the services must be those that, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis. [source: CMS Handbook: Medicare Coverage of Skilled Nursing Facility Care]

Of the total of 977 beds at the SNFs in the county, 710 are currently licensed, 15 are banked under the alternate use provisions of RCW 70.38.111(8)(a) and WAC 246-310-395, and 252 are banked under the full facility closure provisions of RCW 70.38.115(13)(b) and WAC 246-310-396. RCW 70.38.111(8)(d) states:

"Nursing home beds that have been voluntarily reduced under this section [RCW 70.38.111(8)] shall be counted as available nursing home beds for the purpose of evaluating need under RCW 70.38.115(2) (a) and (k) so long as the facility retains the ability to convert them back to nursing home use under the terms of this section."

WAC 246-310-010 states:

"Bed supply" means within a geographic area the total number of:

- *"Nursing home beds which are licensed or certificate of need approved but not yet licensed or beds banked under the provisions of RCW 70.38.111 (8)(a) or where the need is deemed met under the provisions of RCW 70.38.115 (13)(b), excluding:*
- *Those nursing home beds certified as intermediate care facility for the mentally retarded (ICF-MR) the operators of which have not signed an agreement on or before July 1, 1990, with the department of social and health services department of social and health services to give appropriate notice prior to termination of the ICF-MR service;*
- *New or existing nursing home beds within a CCRC which are approved under the provisions of WAC 246-310-380(5); or*
- *Nursing home beds within a CCRC which is excluded from the definition of a health care facility per RCW 70.38.025(6); and*
- *Beds banked under the provisions of RCW 70.38.115 (13)(b) where the need is not deemed met.*
- *Licensed hospital beds used for long-term care or certificate of need approved hospital beds to be used for long-term care not yet in use, excluding swing-beds.*

As required above, the department must count all 977 beds as available in the community.

The ten SNFs in the planning area and the number of licensed and banked beds are shown in Table I, on the following page: [source: Certificate of Need Bed Supply Log, updated June 9, 2005]

Table I
Clark and Skamania County 2005 Bed Count by Skilled Nursing Facility

Name of Facility	# of Licensed Beds	# of AU Banked Beds	# of FFC Banked Beds	Total # of Beds
Cascade Park Care Center	88	0		88
Fort Vancouver Convalescent Center	92	0		92
Heritage Health & Rehab	53	0		53
Highland Terrace Nursing Center	83	7		90
Oregon-Washington Pythian Home	0	0	34	34
Pacific Specialty & Rehab Center	132	0		132
Parkway North Care Center	75	8		83
Rose Vista Nursing Center	0	0	218	218
Discovery Nursing & Rehabilitation*	89	0		89
Vancouver Health & Rehab Center	98	0		98
Total of Nursing Home Beds	**710**	**15**	**252**	**977**

*Previously known as Sunbridge Care & Rehab-Vancouver Hazel Dell Nursing & Rehab Center,

To further assist in its determination whether patients proposed to be served by MCMP would also be candidates for the existing SNFs in the county, the department compared the applicant's proposed average nursing hours per patient day with the existing SNFs' averages. The comparison of the applicant's proposed SNF and the eight SNFs is summarized in Table II below. [source: Medicaid Cost Report data for years 2003 and 2004]

Table II
Average Nursing Hours Per Patient Day Comparison

	RN/PD	LPN/PD	NA/PD	Total NH/PD
MCSC	0.481	0.616	2.005	3.102
Year 2003 Clark-Skamania Averages	0.525	0.530	2.191	3.246
Year 2004 Clark-Skamania Averages[4]	0.522	0.581	2.266	3.369

Based on the summary shown in Table II, the applicant's patients are comparable to the average patient accepted by the existing SNFs in the planning area. Further, when comparing MCSC's proposed RN, LPN, and NA hours per patient day to each individual facility in the county, MCSC closely compares with 2004 data for the patients served at Highland Terrace Nursing Center. Further, based on the nursing hours per patient day alone, MCSC would typically serve a slightly higher acuity patient than Heritage Health and Rehab Center and Vancouver Health and Rehab Center; and a lower acuity patient than Pacific Specialty and Rehabilitation Center, Fort Vancouver Convalescent Center, Cascade Park Care Center, and Discovery Nursing & Rehab of Vancouver. [source: Medicaid Cost Report data year 2004]

In summary, the department concludes that the patients proposed to be served by MCSC would also be appropriate candidates for services by the existing SNFs in the planning area.

Home Health Services

Home health services means services provided to ill, disabled, or vulnerable individuals. Generally a home health patient is homebound, or normally unable to leave home

[4] Year 2004 data does not include patient days/occupancy for Parkway North.

unassisted.[5] Home health services include skilled nursing, home health aide, medical social work, a variety of therapies, and home medical supplies or equipment services. [source: RCW 70.127.010] Home health services are typically provided to patients discharged to their homes by a long-term care facility or hospital for a lower level of care.

Eligibility for Medicare and Medicaid home health services is also governed by CMS. Medicare covers home health services for as long as a patient is eligible and the patient's physician orders the services; however, skilled nursing care and home health aide services are only covered on a part-time or "intermittent" basis. This means there are limits on the number of hours per day and days per week that a patient may receive skilled nursing or home health aid services. Those limits include skilled nursing care needed fewer than seven days each week or less than eight hours each day over a period of 21 days. Medicaid may help with medical costs for some patients, however, to qualify for Medicaid, a patient must be considered a low income patient. [source: CMS Handbook: Medicare and Home Health Care]

As of the writing of this evaluation, the planning area has six home health agencies, and of those, four are Medicare certified. Given that home health care is provided at the patient's residence, capacity for a home health agency is typically measured by its ability to retain or recruit additional staff to meet the needs of the agency's visits. Based on the information above, the department concludes that the home health setting may be appropriate for a number of patients described within the application.

Hospice Services

Hospice programs are designed to offer symptom and pain management to terminally ill patients, and emotional, spiritual, and bereavement support for the patient and family in the final stages of the patient's life. Hospice services may be provided either in the patient's home or within an assisted living or skilled nursing center. [source: RCW 70.127.010] The planning area has one Medicare certified hospice agency. That hospice agency, Home Care and Hospice Southwest, also operates a 20-bed hospice care center. While the applicant has included respite care among the services to be provided, the projected volume of respite care to be provided at MCSC was not indicated. During the course of this review, Home Care and Hospice Southwest did not provide comment on the proposed facility; however a representative of an affiliated entity, Southwest Washington Medical Center, participated in the public hearing and indicated its support for the project on the sign-in sheet for that hearing. Based on this information, the department concludes that the hospice setting would be considered unsuitable for the majority of skilled nursing facility patients described within this application.

As of October 2005, there are 202 adult family homes operating 1,126 beds within the Clark-Skamania planning area. Adult family home means a residential home in which a person or persons provide personal care, special care, room, and board to more than one but not more than six adults who are not related by blood or marriage to the person or persons providing the services. [source: RCW 70.128.010] "Personal care" means both physical assistance and/or prompting and supervising the performance of direct personal care tasks as determined by the resident's needs. Personal care services do not include assistance with tasks performed by a licensed health professional. "Special care" means care beyond personal care services as defined above. [source: WAC 388-76-540]

[5] To be homebound means that leaving home takes considerable and taxing effort. [source: CMS Handbook: Medicare and Home Health Care]

Additionally, as of October 2005, there are 26 boarding homes operating a total of 1,858 beds within the planning area. A boarding home means any home or other institution that provides board and domiciliary care to seven or more residents. "Domiciliary care" is defined as **1)** assistance with activities of daily living provided by the boarding home either directly or indirectly; or **2)** health support services, if provided directly or indirectly by the boarding home; or **3)** intermittent nursing services, if provided directly or indirectly by the boarding home. [source: WAC 388-78A-020]

In previous SNF applications reviewed by CN staff, representatives from the Department of Social and Health Services (DSHS) have stated *"on the average, these types of facilities [adult family homes and boarding homes] are usually about 85% occupied."* However, neither adult family homes nor boarding homes are required to report occupancy data to any regulatory or data gathering entity, which includes its own licensing agency--DSHS. Therefore, the basis for the 85% average occupancy within these two settings has been unavailable and unclear.

To assist in its determination of whether adult family homes or boarding homes are available to meet the needs of the SNF patients in the county, the department enlisted the services of The Gilmore Research Group (GRG) located in the Pacific Northwest. GRG provides research consultation, probability sampling, and data for analysis. For this project, GRG conducted telephone interviews with managers or people in positions of authority at adult family homes and boarding homes in the planning area. The purpose of the interviews was to learn more about the capacity and limitations of these facilities as alternatives to nursing home services. [source: The Gilmore Research Group website and October 18, 2005, report, p1]

For the Clark/Skamania area, GRG contacted 168 of the total of 202 adult family homes (or 83% of the total adult family homes) representing 971 beds and 25 boarding homes (or 96% of the total boarding homes) representing 1,893[6] beds. A summary of the GRG research is shown below.

Adult Family Homes—168 homes representing 971 beds

Below is a breakdown of the payer sources accepted at the 168 homes contacted by GRG.

Payer Sources Accepted	# of AFHs	# of beds	% of Beds (971)
Both Medicare and Medicaid	117	690	71%
Medicare only (not included above)	9	47	5%
Medicaid only (not included above)	29	162	17%
Private Pay only	13	72	7%
Totals	**168**	**971**	**100%**

As shown in the chart above, of the 168 AFH contacted, 117 (or 70%) accept both Medicare and Medicaid patients which represents 690 or 71% of the total AFH beds. In addition to the 117 AFHs that accept both payer sources, 9 more homes would accept only Medicare patients, which increases the percentage of Medicare beds to 76% of the total. Another 29 AFH would accept only Medicaid patients, which increases the percentage of Medicaid beds to 88% of the total. As shown in the chart above, 13 AFHs, representing 72 beds, accept only private pay patients. Given that the majority of SNF

[6] Contacted BH facilities reported more licensed beds than DSHS data indicates in the planning area

patients are Medicare or Medicaid recipients, this portion of the evaluation will focus on the 155 homes that accept either Medicare or Medicaid patients.

GRG also requested the AFH representative to identify any limitations in the types of patients accepted into the facility. Examples of limitations identified by the AFH representatives include:

- non-smokers only;
- ambulatory patients only;
- no HIV/AIDS or terminally ill patients;
- no bariatric [obese] patients;
- no diabetic patients; and
- no mental health or violent behavior patients.

Of the 155 homes accepting either Medicare or Medicaid patients, only 44 offered services with no limitations—representing 244 AFH beds. Further, of the 44 facilities and 244 beds—38 beds were vacant at the time of the survey, which represents an 84.4% occupancy of the 44 facilities. Representatives of the 44 facilities stated that their current number of vacant beds is slightly higher than their facilities' typical vacancy. The 44 facilities reported a total typical vacancy of 26 beds, for a typical occupancy of 89.3%. In summary, while a portion of SNF patients may be served in AFHs, the planning area AFHs that could serve the SNF patients have limitations or few vacancies.

Boarding Homes—25 homes representing 1,893 beds

Below is a breakdown of the payer sources accepted at the 25 homes contacted by GRG.

Payer Sources Accepted	# of BHs	# of beds	% of Beds (1,893)
Both Medicare and Medicaid	5	237	12.5%
Medicare only (not included above)	1	56	2.9%
Medicaid only (not included above)	14	1053	55.6%
Private Pay only	5	547	28.8%
Totals	**25**	**1,893**	**100%**

As shown in the chart above, of the 25 BH contacted, 5 (or 20%) accept both Medicare and Medicaid patients which represents 237 or 12.5% of the total BH beds. In addition to the 5 BHs that accept both payer sources, 1 more BH would accept only Medicare patients, which increases the percentage of Medicare beds to 15.5% of the total. Another 14 BH would accept only Medicaid patients, which increases the percentage of Medicaid beds to 68% of the total. As shown in the chart above, 5 BH, representing 547 beds, accept only private pay patients. Given that the majority of SNF patients are Medicare or Medicaid recipients, this portion of the evaluation will focus on the 20 homes that accept either Medicare or Medicaid patients.

GRG also requested the BH representative to identify any limitations in the types of patients accepted into the facility. Of the 25 BH, 24 had limitations. Examples of limitations identified by the BH representatives include:

- ambulatory patients only;
- no patients requiring skilled nursing care;
- no bariatric [obese] patients; and
- no mental health or violent behavior patients.

Of the 20 boarding homes accepting either Medicare or Medicaid patients, none offered services without limitations. Representatives of the facilities generally stated that their current number of vacant beds is a typical representation of the facility's vacancy, or lack of vacancy. In summary, as with the AFH above, while a few SNF patients may be served in BHs, most SNF patients would not be candidates for the BH setting because of BH limitations and lack of vacancies.

To assist in its demonstration of need for an additional skilled nursing facility in the Clark/Skamania planning area, MCMP provided documentation to support its three assertions restated below. [source: Application, pp8-12; November 3, 2004, supplemental information, pp3-9]

- population growth in the planning area is significant in all elderly population categories while nursing home bed supply has not increased in the last ten years and recently decreased;
- existing nursing homes are fully occupied;
- nursing home bed need methodologies from several other states and from the American Health Care Association, when applied to the planning area, also indicate a need for additional nursing home beds in the planning area; and
- Development of a new hospital in Clark/Skamania is likely to reduce the number of Washington residents seeking nursing home care in Oregon

Based on the documents provided by the applicant to support its above assertions, MCMP concluded that access to care in the planning area is currently limited and families have little, if any, choice in selecting a nursing facility, but to choose the facility with the vacant bed. [source: Application, p12]

Manor Care of Meadow Park (MCMP) states the Clark/Skamania Counties service area is one of the most underserved areas in the nation for skilled nursing beds. In addition, the utilization of the area's skilled nursing facilities (SNF) homes is higher that the state average while the number of available beds per 1000 of persons aged 65 and older is far lower than both the state and national average. Clark County has also recently experienced a decrease in the number of available SNF beds with the closure of two facilities. Therefore, Clark County residents will experience decreased availability in the future years. [source: Application, page 9 and 10]

To assist in its demonstration of need for an additional skilled nursing facility in the planning area, MCMP provided documentation to support its three assertions restated below. [source: Application, pp8-12; November 3, 2004, supplemental information, pp4-8]

- population growth in the planning area is significant in all elderly population categories while nursing home bed supply has not increased appreciably in several years;
- existing nursing homes are fully occupied;
- nursing home bed need methodologies from several other states and from the American Health Care Association, when applied to the planning area, also indicate a need for additional nursing home beds in the planning area.

Based on the documents provided by the applicant to support its above assertions, MCMP concluded that access to care in the planning area is currently limited and families have little, if any, choice in selecting a nursing facility, but to choose the facility with the vacant bed. The applicant utilized two techniques to evaluate the evidence demonstrating a need

for additional SNF beds: first the statistical method and secondly, the practical signs and anecdotal instances, as summarized below: [source: Application, page 8 and 9]

MCMP asserts that the above evidence demonstrates that "…the residents of the planning area have limited access to care and little access to choice." [source: Application, page 8] Further, the Department of Social and Health Services (DSHS) nursing home projections illustrate Clark/Skamania counties currently have 25 SNF beds for every 1,000 persons aged 65+ (24/1,000). By the completion of this project in late 2007, the planning area will need an additional 801 beds to reach the state's guideline of 40/1,000.

Five SNFs in the planning area provided information in opposition to this project related to these criteria. [source: March 23, 2005, public comment and public hearing documents submitted by each facility] Additionally, comments in opposition were provided by the following four entities:

- Department of Social and Health Services, Aging and Adult Administration Division [source: December 16, 2004, public comment]
- Highland Terrace Nursing Center and Parkway North Care Center, vice president of operations for operator [source: January 14, 2005, public comment]
- Vancouver Health and Rehab, executive director [source: February 28, 2005, public comment]
- Discovery Nursing & Rehab, administrator [source: February 28, public comment]
- Fort Vancouver Convalescent Center, associate administrator [source: February 28, public comment]

In order to assess these comments and concerns and to examine skilled nursing care in the planning area more closely, the department used data submitted by the applicant, data submitted in support of the application, and data submitted in opposition to the application. Further, the department reviewed historical cost reports obtained from DSHS. This information includes annual Medicaid cost report raw data and summaries for 2003 and 2004 for all Washington State SNFs--both community and hospital-based--eligible to provide Medicaid services for Washington State residents. A summary of the department's review is shown below by topic, and excerpts of the comments provided in opposition are addressed by topic where appropriate.

Population growth in Clark/Skamania Planning area

MCMP asserts that population growth in the planning area is significant and nursing home beds have not increased in several years. The existing providers did not comment on this assertion made by the applicant.

To evaluate this assertion, the department obtained population data from the Office Financial Management (OFM) for both Washington State and Clark and Skamania Counties. In January 2002, OFM released new county and state projections for the Growth Management Act. The projection series starts with the year 2000 census as a base and uses actual growth trends through the 1990s and prior historical periods to develop county growth expectations. In January 2004, OFM published a tracking report to evaluate how the annual population estimates for 2001 through 2003 line up with the 2005 Growth Management Act projections.[7] The tracking report provided the following summaries regarding population growth in Washington.

[7] The full tracking report can be obtained at http://www.ofm.wa.gov/pop/index/htm#growth.

- one-third of the counties are tracking closely--within one percent--of the 'intermediate' series range;[8]
- all but two counties (Franklin and Pend Oreille) are tracking within the high and low projection series range; and
- about 70% of the counties are tracking below their intermediate projection series.

The OFM document shows that Clark County is tracking within 1.5% of the intermediate series. Skamania County is also tracking very close to the intermediate series.

On June 28, 2005, OFM provided a press release regarding Washington State growth. Within that press release, OFM indicates that Washington State's population has grown approximately 1.4%, in the past year, which is slightly higher than the 1.1 % growth in the previous year. Further, the document identified the fastest growing counties based on the percentage of change since the 2000 census. Those counties are Benton, **Clark**, Franklin, and San Juan.

Area	2005 Population Estimate	% change from 2000-2005	# of persons 65 & older	% of persons 65 & older
Washington	6,256,400	6.15%	712,092	11.4%
Clark/Skamania	401,800	13.1%	40,434	10.1%

As shown above, the planning area's overall population growth is larger and its percentage of persons 65 and older is slightly lower when compared to the state.

The chart below compares the planning area's growth with three of the four counties identified by OFM as the fastest growing counties -- Benton, Franklin, and San Juan[9]. That comparison is shown below.

County	2005 Population Estimate	% change from 2000-2005	# of persons 65 & older	% of persons 65 & older
Clark/Skamania	401,800	13.14%	40,434	10.06%
Franklin	60,500	22.60%	5,055	8.3%
Benton	158,100	10.97%	16,067	10.2%
San Juan	15,500	10.11%	2,886	18.6%

As shown above, the planning area's percentage of persons 65 and older is higher than all counties, with the exception of San Juan. Finally, the department compared the [planning area's age 65 and older population growth to the state as a whole.

Area	Year 2000 # of persons 65 & older	Year 2005 # of persons 65 & older	% change from 2000-2005
Washington	662,148	712,092	6.15%
Clark/Skamania	33,894	40,434	19.3%

As shown above, the planning area's percentage of growth in the age 65+ group is considerably larger than the state as a whole. Based on OFM data and US Census Bureau data sources, the department concurs with the applicant regarding growth in the county.

[8] Projections are provided by three series: low, intermediate, and high. Low series projections would project a slower growth than both the intermediate or high series. Under usual and normal circumstances, the CN Program bases its projections on the intermediate series.

[9] The fourth county, Clark, is one of the two counties in the planning area in this review

Existing nursing homes are fully occupied

MCMP asserts that the existing facilities in the county are either fully occupied or operating at a high utilization. In response, the existing providers submitted extensive comments regarding the utilization of their facilities and asserted that the occupancy in the county is not high. The providers indicate that adequate beds are available to the residents and an additional provider in the county is not necessary.

As previously stated, there are 977 beds distributed among ten SNFs in the planning area. Of the 977 beds, 710 are currently licensed, 15 are currently banked under alternate use, and 252 are banked under full-facility closure. [source: Certificate of Need Bed Supply Log, October 15, 2005] RCW 70.38.111(8) allows a SNF to voluntarily reduce or "bank" a number of its licensed beds to provide alternative services or otherwise enhance the quality of life for its residents. Once approved, the beds that are banked are de-licensed by DSHS. Additionally, beds banked under this provision may be banked for four years, with an option to renew for another four years, for a maximum bed banking of eight years. To convert beds back to nursing home beds under these provisions, the SNF must:

1) maintain eligibility for the beds currently banked; and
2) provide a minimum of 90 days notice to the CN Program that it intends to re-license the beds.[10]

A review of Certificate of Need Program files reveals that the 7 beds currently banked under alternate use at Highland Terrace Nursing Center were banked on June 30, 2001. On June 30, 2005, the department approved Highland Terrace Nursing Center's request to extend the bed banking for the 7 beds to June 30, 2009.

Certificate of Need Program files also show that the 8 beds currently banked under alternate use at Parkway North Care Center were banked on June 30, 2001 and extended until June 30, 2009.

RCW 70.38.111(8)(d) requires the department to count beds banked under alternate use as available nursing home beds for the purpose of evaluating need for additional beds in CN applications. Given banked beds may be converted to skilled nursing use after a 90 day notice, it is reasonable to assume that they are, in fact, available.

RCW 70.38.115(13)(b) allows a SNF to bank beds in the event a facility ceases operations. Those beds may be reserved for up to eight years. In the event the licensee who banked the beds chooses to replace those beds a new certificate of need is required. If the licensee operated those beds for at least one year immediately prior to the facility closure and is proposing to replace those beds in the same planning area, the project is subject to the financial feasibility, structure and process of care, and cost containment criteria; however, the criterion of need is deemed met. Because these beds may be replaced without examination of need for additional beds, these banked beds are also counted for the purpose of evaluating need for additional beds in CN applications.

Certificate of Need Program files reveal that the Oregon-Washington Pythian Home banked 34 beds under full-facility closure on August 13, 1999. Those beds are eligible for conversion until August 13, 2007.

[10] Additional requirements for converting beds back to skilled nursing use are found in RCW 70.38.111(8).

Certificate of Need Program files also indicate that Rose Vista Nursing Center banked 218 beds under full-facility closure on July 21, 2003. Those beds are eligible for conversion until July 21, 2011.

The 15 beds banked under alternate use and the 267 beds banked under full-facility closure are counted in the numeric bed projection methodology, which projects 727 additional beds could be added to Clark and Skamania counties to bring the planning area to the established 40/1,000 ratio in projection year 2007.

For DSHS cost reporting purposes, facility occupancy is reported on the number of licensed beds within a facility. Tables III below summarizes the occupancy of licensed SNF beds in operation in years 2003 and 2004 at the total of ten SNFs in the Clark/Skamania planning area. [source: Year 2003 and 2004 DSHS cost report data and Year 2003 and 2004 CHARS data]

Tables III
Clark/Skamania Year 2003 Number of Beds and Average Occupancy

	# of Lic'd Beds	Bed Occp'y %	# of Lic'd Beds Available	Plus AU/FFC Banked Beds
Cascade Park Care Center	88	96	4	
Fort Vancouver Convalescent Ctr	92	86	13	
Heritage Health & Rehab	53	87	7	
Highland Terrace Nursing Center	83	89	9	7
Oregon-Washington Pythian Home	0	0	0	34
Pacific Specialty & Rehab Center**	132	89	15	
Parkway North Care Center	75	86	10	8
Rose Vista*	218	73	59	
Sunbridge Health & Rehab-Vancouver	89	82	16	
Vancouver Health & Rehab Ctr	98	92	8	
Totals/ Average Occupancy	**928**	**86.7%**	**141**	**49**

*Facility closed July 21, 2003, banking 218 beds under Full Facility Closure provisions in WAC 246-310-396.

Clark/Skamania Year 2004 Number of Beds and Average Occupancy

	# of Lic'd Beds	Bed Occp'y %	# of Lic'd Beds Available	Plus AU/FFC Banked Beds
Cascade Park Care Center	88	98	2	
Fort Vancouver Convalescent Ctr	92	92	7	
Heritage Health & Rehab	53	86	7	
Highland Terrace Nursing Center	83	90	8	7
Oregon-Washington Pythian Home	0	0	0	34
Pacific Specialty & Rehab Center**	132	91	12	
Parkway North Care Center	75	84	12	8
Rose Vista*	0	0	0	218
Discovery Nursing & Rehab of Vancouver	89	84	14	
Vancouver Health & Rehab Ctr	98	91	8	
Totals/ Average Occupancy	**710**	**89.5%**	**70**	**267**

*Facility closed July 21, 2003, banking 218 beds under Full Facility Closure provisions in WAC 246-310-396.

On July 21, 2003, Rose Vista discharged its last resident and banked 218 beds under full facility closure provisions. Pacific Specialty, in response to this closure, converted a total of 21 beds. This conversion increased Pacific Specialty's number of licensed beds to 132.

Additionally, shown in Tables III, in year 2003, with 49 beds banked under alternate use and full-facility closure, the planning area's average occupancy was 86.7%. In year 2004, with 218 fewer beds licensed and a total of 237 beds banked under alternate use and full-facility closure, the planning area occupancy increased by nearly three percent, from 86.7% to 89.5%. Both occupancy percentages are slightly above the statewide average for years 2003 and 2004 of 83% and 86%, respectively.

Representatives from Highland Terrace and Parkway North suggest that occupancy of existing homes should be calculated using all CN-approved beds, including beds banked under alternate use and full-facility closure, resulting in an occupancy of approximately 65%. The department disagrees, noting that while all beds are counted the calculations to determine future need, utilization of existing, licensed beds is an appropriate measure of the utilization of existing facilities.

In conclusion, in addition to the 710 licensed and 267 banked SNF beds available in the planning area, the department determined an average of 26 AFH beds and no unrestricted BH beds could be available to the residents of the planning area, for a total of 1,003 SNF or alternative beds available. Calculating the planning area bed to population ratio of persons 65 and older reveals that the planning area's ratio would increase from its current 25/1,000 to 26/1,000. Additionally, adding the 120 beds proposed in this project to the 1,003 available beds, for a total of 1,123 beds, brings the planning area's ratio to 29/1,000. Both ratios continue to be under the 40/1,000 ratio used for projecting total bed need for SNFs in the state and within a planning area

Nursing home bed need methodologies from several other states and from the American Health Care Association, when applied to the planning area, also indicate a need for additional nursing home beds in the planning area

MCMP asserts that additional beds should be added to the planning area because applying other methodologies from several other states and the American Health Care Association to the Clark/Skamania planning area indicates a need for additional nursing home beds in the county. The existing providers did not comment on this assertion made by the applicant.

The program is required, by statute and rule, to consider a variety of information and apply a numeric methodology to determine need for additional skilled nursing beds in Washington State and within a specific planning area. Washington's own methodology required by statute and rules supercedes any other methodology from other states.

Development of a new hospital in Clark/Skamania is likely to reduce the number of Washington residents seeking nursing home care in Oregon

MCMP provided summarized information from the department's March 2002 evaluation that resulted in the award of a Certificate of Need to Legacy Health Systems to establish a new hospital in the Salmon Creek area of Clark County, near MCSC's proposed location. In that evaluation, the department noted that over 35% of Clark County residents' acute care patient days are spent outside Clark County. 89% of those days are spent in Oregon hospitals. MCMP noted that most nursing home stays come immediately following a stay

in a nearby hospital. MCMP used this logic to demonstrate that if the department's rationale in approving the Legacy Salmon Creek Hospital is valid, it is reasonable to expect that an increased number of Clark/Skamania residents will be referred to facilities in the planning area, rather than in Oregon.

In a closely related argument, MCMP provided a comparison of nursing home bed days in the Clark/Skamania planning area and Multnomah County, Oregon, from 2001 to 2003. MCMP contends that the date shown illustrates a shift in referral from Clark/Skamania to Oregon following the closure of two nursing homes in the planning area.

The department cannot, on the basis of the Oregon data discussed above, conclude that the closure of two nursing facilities caused the referral patterns illustrated in that table, but the department does conclude that the opening of Legacy Salmon Creek Hospital is likely to result in increased referrals to planning area nursing homes. Like MCMP, the department is unable to quantify that increase, but it does conclude that it is a consideration in determining need for additional nursing home beds in the Clark/Skamania planning area.

On the basis of the information provided during the review of this project and research by Certificate of Need staff, the department concludes that need for a 120-bed skilled nursing facility in the Clark/Skamania planning area is supported by the data. Given the limited availability and accessibility of the existing providers in the planning area, the department concludes an additional SNF is necessary to meet the projected need in the community. As a result, the department concludes that this sub-criterion is met.

(2) *All residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services.*

As previously stated, the subsidiary of MCMP currently operates a variety of health care facilities in Washington State. Through these health care facilities, MCMP provides health care services to residents of the service area including low-income, racial and ethnic minorities, handicapped and other underserved groups. To demonstrate compliance with this sub-criterion, MCMP provided a copy of its draft Admission Agreement. A review of the draft agreement indicates that patients would appropriately be admitted to MCSC provided that the patient was a candidate for nursing care. [source: November 3, 2004, supplemental responses, Attachment 9

Additionally, MCMP provided a copy of the Manor Care Resident Handbook, which is provided to each resident upon admittance to the facility. The handbook states that Manor Care will not discriminate in its admissions decisions based on race, color, religion, sex, national origin, age, mental or physical handicap or communicable or contagious disease. In addition, the resident handbook discusses the patient's right to dignity, respect and personal safety as a resident of MCSC. [source: November 3, 2004, supplemental responses, Attachment 8]

To determine whether low income residents would have access to MCSC, the department uses the facility's Medicaid eligibility or contracting with Medicaid as the measure to make that determination. Given that MCSC is not currently operating, a contract with Medicaid is not yet established. Documents provided in the application demonstrate that MCMP would establish the appropriate relationships with both Medicare and Medicaid for MCSC.

While both documents above demonstrate the applicant's intent to comply with this sub-criterion, if this project is approved, to ensure MSC would continue to comply with this requirement, MCMP would have to agree to the following term:

> Prior to commencement of the project, Manor Care of America, Inc. shall provide to the department a copy of the Manor Care of Salmon Creek's final Admissions Agreement. This agreement must state that all services at this facility will be accessible to all persons without regard to race, color, ethnicity, sexual preference, disability, national origin, age or inability to pay.

Based upon the information presented in the application and agreement to the above term, the department concludes all residents would have access to MCSC, and this sub-criterion would be met.

B. Financial Feasibility (WAC 246-310-220)

Based on the source information reviewed, the department determines that the application is consistent with the applicable financial feasibility criteria in WAC 246-310-220.

(1) The immediate and long-range capital and operating costs of the project can be met.

As stated earlier, the estimated capital expenditure for this project is $11,924,000. The project funding source is the cash, cash equivalents and a revolving line of credit available to Manor Care, Inc., the parent company. [source: Application, pp4, 22] To demonstrate Manor Care, Inc.'s commitment to this project, the applicant provided a letter supporting the project from the parent company's Chief Financial Officer, Mr. Geoffrey G. Meyers. [source: Application, exhibit 9]

Additionally, to determine whether MCSC could meet its immediate and long range operating costs, the department evaluated MCSC's projected balance sheets for the first three years of operation as a 120 bed facility. A summary of the balance sheets is shown in Table IV below: [source: Application, Appendix 10; Appendix 11 Schedule B]

Tables IV
MCSC Balance Sheet for Projected Years 2008-2010

Year 2008

Assets		**Liabilities**	
Total Current Assets	$ 263,374	Total Current Liabilities	$ 172,242
Fixed Assets	$ 12,048,700	Other Liabilities	$ 11,985,385
Accum. Depreciation	($ 433,930)	**Total Liabilities**	**$ 12,157,627**
		Equity	($ 279,483)
Total Assets	**$ 11,878,144**	**Total Liabilities and Equity**	**$ 11,878,144**

Year 2009

Assets		**Liabilities**	
Current Assets	$602,768	Current Liabilities	$ 350,426
Fixed Assets	$ 12,108,700	Other Liabilities	$ 11,923,281
Accum. Depreciation	($ 439,930)	**Total Liabilities**	**$ 12,273,707**
		Equity	($ 2,169)
Total Assets	**$ 12,271,538**	**Total Liabilities and Equity**	**$ 12,271,538**

Year 2010

Assets		Liabilities	
Current Assets	$ 870,777	Current Liabilities	$ 492,450
Fixed Assets	$ 12,396,700	Other Liabilities	$ 11,618,426
Accum. Depreciation	($ 468,740)	**Total Liabilities**	**$ 12,110,876**
		Equity	$ 687,861
Total Assets	**$ 12,798,737**	**Total Liabilities and Equity**	**$ 12,798,737**

In addition to the projected balance sheets provided above, the applicant also provided its Statement of Operations for years 2008 through 2010 as a 120 bed facility. [source: November 3, 2004 screening responses, Exhibit 11, Schedule C] A summary of the Statement of Operations is shown in Table V, below :

Table V
Manor Care of Salmon Creek of Operations Summary
Projected Years 2007 through 2009

	Year One (2007)	Year Two (2008)	Year Three (2009)
# of Beds	120	120	120
# of Patient Days	11,826	28,470	41,610
% Occupancy	27%	65%	95%
Net Revenue	$2,729,769	$6,571,667	$9,604,744
Total Expense	$3,009,251	$6,294,353	$9,814,715
Net Profit (Loss)	($279,482)	$277,314	$690,029
Net Revenue per patient day	$230.83	$230.83	$230.83
Total Expenses per patient day	$254.46	$221.09	$214.24
Net Profit (Loss) per patient day	($23.63)	$9.74	$16.58

As shown in Table V above, MCSC anticipates it will operate at a loss in the first full year of operation, with profits increasing by the second and third full years of operation as demonstrated using the projected utilization.

In Washington State, Medicaid nursing facility rates are set by the Nursing Home Rates Section of the Office of Rates Management part of the Aging and Disability Services Administration of the Department of Social and Health Services. Medicaid rates for long term care nursing facilities are set individually for each specific facility. Rates are based generally on a facility's costs, its occupancy level, and the individual care needs of its residents. The Medicaid payment rate system does not guarantee that all allowable costs relating to the care of Medicaid residents will be fully reimbursed. The primary goal of the system is to pay for nursing care rendered to Medicaid-eligible residents in accordance with federal and state laws, not to reimburse costs--however defined--of providers. A facility's overall Medicaid rate is comprised of rates for the following seven separate components:

- Direct care - nursing care and related care provided to residents
- Therapy care - speech, physical, occupational, and other therapy
- Support services - food and dietary services, housekeeping, and laundry
- Operations - administration, utilities, accounting, and maintenance
- Variable return - an incentive payment for relative efficiency
- Property - depreciation allowance for real property improvements, equipment and personal property used for resident care

- Financing allowance - return on the facility's net invested funds i.e., the value of its tangible fixed assets and allowable cost of land

For existing nursing homes, the component rates are based on examined and adjusted costs from each facility's cost report. Direct care, therapy care, support services, operations and variable return component rates for July 1, 2001, through June 30, 2004, are based on 1999 cost reports. Property and financing allowance components are rebased annually. For new nursing homes, such as this project, the initial Medicaid rate is set using a peer group review. [source: DSHS WAC 388-96-710(3)]

All component rates require, directly or indirectly, use of the number of resident days--the total of the days in residence at the facility for all eligible residents--for the applicable report period. Resident days are subject to minimum occupancy levels. Effective July 1, 2002, the minimum occupancy for direct care, therapy care, support services, and variable return component rates is 85%; for operations, financing allowance, and property component rates, the minimum occupancy rate is 90%.[11] If resident days are below the minimum, they are increased to the imputed occupancy level, which has the effect of reducing per resident day costs and the component rates based on such costs. If the actual occupancy level is higher than the minimum, the actual number of resident days is used. [source: An Overview of Medicaid Rate Setting for Nursing Facilities in Washington provided by DSHS]

Information obtained from the Office of Rates Management within DSHS indicates that MCSC's Medicaid reimbursement rate would be approximately $176 per patient day. Within the pro forma Statement of Operations, MCMP projected the reimbursement rate to be $147.20; therefore, the department concludes that the estimated revenues in Table V are reasonable. The department compared the estimated expenses for MCSC to the annual expenses of the existing SNFs in the planning area, and that comparison revealed that the estimated expenses in Table V are also reasonable. [source: February 15, 2005, DSHS summary review and 2004 cost report summaries]

To further analyze short-term and long-term financial feasibility of nursing home projects and to assess the financial impact of a project on overall facility operations, the department uses a financial ratio analysis. The analysis assesses the financial position of an applicant, both historically and prospectively. The financial ratios utilized are: **1)** current assets to current liabilities; **2)** current and long-term liabilities to total assets; **3)** total operating expense to total operating revenue; and **4)** debt service coverage ratio. If a project's ratios are within the expected value range, the project can be expected to be financially feasible. Table VI, on the following page, summarizes the project's financial ratios. [source: November 3, 2004 screening responses, Exhibit 11]

[11] For essential community providers--i.e., facilities at least a forty minute drive from the next closest nursing facility--the minimum occupancy is set at 85% for all components in recognition of their location in lesser-served areas of the state. MCSC would not meet the definition of an essential community provider.

Table VI
MCSC Projected Financial Ratios

RATIO	GUIDELINE:	*	Year 1 2008	Year 2 2009	Year 3 2010
Current Ratio	1.8-2.5	Above	1.53	1.72	1.77
Assets Financed by Liabilities	.60-.80	Below	0.01	0.03	0.04
Total Operating Expense to Total Operating Revenue	1.0	Below	1.17	0.93	0.88
Debit Service Coverage	1.5-2.0	Above	N/A	N/A	N/A

*A project is considered more feasible if the ratio is above or below the value/guideline as indicated.

The applicant provided the following statement in reference to the ratios: [source: Application, Exhibit 12]

> *"Due to the accounting of interunit transactions between the facility and the Corporate entity, the true value of some of the facilities assets and liabilities are not accurately represented, (i.e. the facility does not keep its own cash, therefore they show a minimal cash balance). This obviously affects the ratio calculations shown above."*

As shown in Table VI above, the current ratio is slightly below Washington State's average in the first three years of operation. This means that the facility's total current liabilities would be slightly higher than the usual; however, given the cost to establish a new facility, the ratio is not unreasonable. The assets financed by liabilities ratio of MCSC is favorably below the state average, and the total operating expense to total operating revenue, is also favorably below the state average by the end of the third year of operation. As the financing for this project is a cash transaction, the debit service ratio is not applicable. Therefore, the department concludes MCSC's financial ratios, as illustrated in Table VI, demonstrate that the project is financially feasible.

Based on the financial information above, the department concludes that the long-term capital and operating costs of this project would be met. This sub-criterion is met.

(2) The costs of the project, including any construction costs, will probably not result in an unreasonable impact on the costs and charges for health services.

MCSC's per patient day costs were compared to the year 2004 costs of the other SNFs in the planning area. On the basis of that comparison, MCSC's per patient day costs are slightly higher than the other nine, however, MCSC's costs do not appear to be unreasonable. [source: 2004 DSHS cost report summaries] This sub-criterion is not met.

(3) The project can be appropriately financed.

The capital expenditure associated with the development and construction of MCSC is estimated to be $11,924,000. [source: November 4, 2004, supplemental information, Exhibit 11] A breakdown of the capital expenditure associated with this project is shown on the following page: [source: November 4, 2004 supplemental information, Appendix 11]

Item	Amount
Construction Costs	$ 6,532,510
Land Purchase & Site Preparation	1,968,700
Equipment (Fixed and Moveable)	1,590,000
Corporate Overhead	873,500
Washington State Sales Tax	531,490
Fees	402,800
Real Estate Tax	25,000
TOTAL	**$ 11,924,000**

The source of financing for the project will be from Manor Care, Inc. cash reserves. [source: November 4, 2004, supplemental information, p12] To confirm Manor Care, Inc.'s commitment to fund the project, the applicant provided a letter of support from the Chief Financial Officer, assuring the financing for the total development of MCSC. Effective December 31, 2003, Manor Care, Inc. had $86.2 million in cash and cash equivalents. [source: Application, Exhibit 9] To demonstrate compliance with this sub-criterion, MCMP provided Manor Care, Inc's most recent two-year historical financial documentation. [source: Application, Exhibit 10] Those documents confirm that Manor Care, Inc. currently has the funds to finance the project, and this project would not adversely affect the financial stability of Manor Care, Inc.

As of the writing of this evaluation, Manor Care, Inc. or one of its subsidiaries has four projects under Certificate of Need review in Washington State. Of those four projects, two propose to establish new 120 bed SNFs—this project in Clark County and one in Thurston County; the remaining two projects each propose to add beds to an existing SNF--a 20 bed addition in Pierce County and a 27 bed addition in Snohomish County. Within all four applications, Manor Care, Inc. proposes to fund all four projects through its cash reserves. When combined, these four projects total to $30,553,820.

To evaluate whether Manor Care Inc. has the funds available for this project, and its other projects proposed in Washington State, the department reviewed Manor Care, Inc.'s most recent consolidated balance sheet for year 2004. [source: Manor Care, Inc. website] A summary of the balance sheet is shown below.

Year 2004

Assets		Liabilities	
Current Assets	$ 540,367,000	Current Liabilities	$ 402,254,000
Fixed Assets	$ 1,495,152,000	Other Liabilities	$ 954,285,000
Other Assets	$ 305,179,000	**Total Liabilities**	**$ 1,356,539,000**
		Equity	$ 984,159,000
Total Assets	**$ 2,340,698,000**	**Total Liabilities and Equity**	**$ 2,340,698,000**

This project's costs of $11,924,000 represent .51% of Manor Care, Inc.'s total assets, and 36% of its $32,915,000 in cash and cash equivalents. For all four projects currently under review in Washington State, $30,553,820 represents 1.3% of the total assets, and 93% of Manor Care, Inc.'s cash and cash equivalents.

Based on the above information, the department concludes that funding for this project is available based on the 2004 financial data. At this time, while Manor Care, Inc has several projects undergoing construction, renovation, or modification, it appears that its Washington State projects could be funded. This sub-criterion is met.

As a Certificate of Need is site specific, the applicant provided a copy of the executed Earnest Money and Purchase and Sale Agreement to identify the site. [source: November 4, 2004, supplemental information, exhibit 6] The department acknowledges that this agreement demonstrates intent, however, if this project is approved, in order to comply with the issuance of a Certificate of Need, the MCSC must agree to the following terms.

> Prior to commencing this project, the applicant must provide to the department for review and approval an executed copy of the clear title to the proposed site located at 14906 NE 20th Avenue, Salmon Creek.

Based on the documentation provided in the application, and with agreement to the above term, the department concludes that this sub-criterion is met.

C. Structure and Process (Quality) of Care (WAC 246-310-230)

Based on the source information reviewed, the department determines that the application is consistent with the applicable structure and process of care criteria in WAC 246-310-230.

(1) A sufficient supply of qualified staff for the project, including both health personnel and management personnel, are available or can be recruited.

Table VII, on the following page, summarizes the projected number of FTEs to staff the 120 bed MCSC in the third year of operation, with 95% projected occupancy. [source: Application, page 26]

Table VII
Manor Care of Salmon Creek Projected FTEs

Staff	Projected FTEs
RN	9.6
LPN	12.3
Nurses Aides & Assistants	40.0
Dietitians	1.0
Aides	10.1
Administrator	1.0
Assistant Administrator	0
Administrator In-Training	0
Activities Director & Assistant	2.0
In-Service Director (RN)	1.0
Director of Nursing & ADON	2.0
Clerical	3.5
Housekeeping/Maintenance	6.9
Laundry	3.5
Physical Therapist & Aides	5.5
Occupational Therapist & Aides	3.5
Pharmacist	0
Medical Records	1.0
Social Worker	3.0
Plant Engineer	1.0
Other[12]	9.4
Total FTEs	**116.3**

[12] Human Resource Director, Speech Therapist, Admission Coordinator, Case Manager, MDS Coordinators, Nurse Specialists

To assure the department of MCMP's recruitment qualifications, the applicant provided a comprehensive staffing policy and procedure. Manor Care, Inc. has a total of over 400 types of centers/facilities and over 30 years of experience in staff recruitment. Historically, Manor Care, Inc. has staffed its facilities by a using a variety of alternatives, e.g. bonuses, scholarships, tuition reimbursement programs, transfer opportunities, affiliatations with nursing schools and participation in a National advertising campaign. [source: Application, Exhibit 13] On review of the policy and procedure, the department concludes that the applicant's national presence offers reasonable assurance of Manor Care, Inc.'s staffing capability.

MCMP also stated at the public hearing that, as a large multi-state corporation, MCMP has a large pool of staff that might be transferred to a new facility to supplement local recruitment efforts.

Based on the above evaluation and information provided in the application, the department concludes that qualified staff are available or can be recruited. This sub-criterion is met.

(2) The proposed service(s) will have an appropriate relationship, including organizational relationship, to ancillary and support services, and ancillary and support services will be sufficient to support any health services included in the proposed project.

Manor Care, Inc. is an established provider of SNF services in Washington State, as such; some ancillary and support services established. MCSC will participate in a corporate national contract for pharmacy, IV therapy and radiology services. The applicant identified the remaining ancillary and support services required, however, as the facility has yet to be constructed, local providers had not yet been contacted and "will be contacted at the appropriate time to establish contracts for services." [source: Application, page 27, Exhibit 17; November 4, 2004, supplemental information, p15]

As indicated above, some ancillary and support services will be provided through a national contract with Manor Care, Inc. and some will be provided by community providers in the planning area. Based on the information provided in the application, the department concludes that MCMP intends to meet this requirement; however, if this project is approved, to ensure that appropriate agreements will be established, the applicant must agree to the following term:

> Prior to providing services at MCSC, the applicant will provide functional plans outlining the services to be provided through a national contract with Manor Care, Inc. and those that would be provided within the Clark/Skamania County planning area.

Provided that the applicant would agree to the term outlined above, the department would conclude that there is reasonable assurance that MCSC would have appropriate ancillary and support services, and this sub-criterion would be met.

(3) There is reasonable assurance that the project will be in conformance with applicable state licensing requirements and, if the applicant is or plans to be certified under the Medicaid or Medicare program, with the applicable conditions of participation related to those programs.

As stated in the project description portion of this evaluation, Manor Care of Meadow Park, Inc. is located in Delaware and is the operating group of Manor Care, Inc, an owner and operator of long term health care centers in the United States. As of the writing of this evaluation, Manor Care, Inc. has over 500 skilled nursing centers, assisted living facilities, outpatient rehabilitation clinics, and hospice and home health offices in 33 states.[13] The majority of the health care facilities are operated under the names of, or dba of, Manor Care, Arden Courts, Springhouse, and Heartland.

To evaluate this sub-criterion, the department requested quality of care histories from the states where HCR Manor Care, or any of its subsidiaries, owns or operates healthcare facilities--which represents a total of 571 health care facilities. Of the 33 states, 20 states provided detailed documentation related to the quality care history and 13 states did not respond.[14] The 20 states that responded represent 440 healthcare facilities--or 77% of the 571 facilities owned or operated by HCR Manor Care, or its subsidiaries. Of the 20 states that responded, nine indicated significant non-compliance issues[15] at one or more of the healthcare facilities operated by HCR Manor Care or one of its subsidiaries.[16] There are a total of 121 facilities within the nine states, and of those, 24 facilities--or 20%--indicated significant non-compliance issues that were subsequently corrected by HCR Manor Care or one of its subsidiaries. Further, the majority of the significant non-compliance citations related to isolated incidences and did not represent immediate jeopardy to patients. [source: compliance survey data provided by each state agency] According to documents provided by the out-of-state licensing agencies, HCR Manor Care resolved the significant non-compliance issues and no disciplinary actions were taken by the out-of-state surveying agencies.

As stated in the project description portion of this evaluation, HCR Manor Care owns or operates four skilled nursing facilities and Heartland owns or operates two in-home services agencies in Washington State. A review of the quality of care histories from those six healthcare facilities for years 2001 through 2004 revealed no significant non-compliance issues at any of the six facilities.

Based on the above information, the department concludes that there is reasonable assurance that Manor Care of Salmon Creek would operate in conformance with applicable state and federal licensing and certification requirements as a 120 bed facility. This sub-criterion is met.

(4) The proposed project will promote continuity in the provision of health care, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the service area's existing health care system.

In its response to this criterion, the applicant identified medical providers within the service area and stated its intention to establish referral relationships and transfer agreements with the existing health care system. [source: November 4, 2004, supplemental information] MCMP also provided a document titled “Service Integration” that describes MCMP’s strategy and plan

[13] States include: Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Maryland, Michigan, Minnesota, Missouri, North Carolina, North Dakota, Nevada, New Jersey, New Mexico, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin.

[14] States that did not respond: Arizona, Georgia, Kentucky, Maryland, Missouri, North Dakota, New Jersey, New Mexico, Oklahoma, South Carolina, South Dakota, Texas, and Virginia.

[15] For purposes of this evaluation, ‘significant’ non-compliance issues are defined as: 1) substandard care citations resulting in F-tags with scope and severity level “H” or above; 2) immediate jeopardy citations F-tags with scope and severity level “J” or above; and 3) surveys resulting in state or federal remedies (typically received for continued non-compliance beyond timeframes allowed in state or federal regulations).

[16] States indicating significant non-compliance issues: California, Colorado, Connecticut, Indiana, Iowa, Michigan, Nevada, Tennessee, and West Virginia

for establishing and maintaining relationships with existing healthcare providers and social services. [source: application, appendix 17] MCMP also noted at the public hearing that its proximity to the new Legacy Salmon Creek Hospital and plans to certify 60 of its 120 beds for Medicare patients will facilitate the transition for patients between the hospital and home.

The department concludes that MCMP has provided a reasonable plan to enter and participate in the healthcare system of Clark and Skamania counties. Therefore, this sub-criterion is met.

(5) There is reasonable assurance that the services to be provided through the proposed project will be provided in a manner that ensures safe and adequate care to the public to be served and in accord with applicable federal and state laws, rules, and regulations.
This sub-criterion is addressed in sub-section (3) above.

D. Cost Containment (WAC 246-310-240)
Based on the source information reviewed, the department determines that the application is consistent with the applicable cost containment criteria in WAC 246-310-240.

(1) Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable.
In response to this sub-criterion, the applicant reviewed the following alternatives for this project. [source: Application, page 28, 29]

Do nothing
This alternative was rejected due to the applicant's assertion that the existing skilled nursing facilities are operating at a high occupancy, coupled with a large projected growth in the 85+ population. Additionally, the applicant determined that a "do nothing" approach would not address:

- The out migration of Clark County SNF patients to Oregon or other counties care would not be addressed.
- The current status of a SNF beds would enable a continuation of receiving care at inappropriate levels would exist.
- The applicant's position that competition results in "a quality service at a marketable price."

Purchase or lease an existing building to convert to nursing home care
MCMP states that there is no building in the Salmon Creek area that could be converted to a SNF. The applicant further stated that construction requirements for a "modern" facility are not conducive to the conversion of an existing structure to nursing home use. Additionally, the increased operating costs for a conversion rather than a new construction may not be financially attractive, could be more costly and less efficient.

Expansion of existing facilities
Although Clark County experienced a SNF closure (Rose Vista Nursing Center for a total of 218 beds), MCMP notes that none of the current SNFs filed a Letter of Intent or an Application to address the identified bed shortage by the addition of SNF beds.

Construct a new facility
MCMP states: "This alternative has several advantages. It will directly address the need for more beds, provide additional competition to the market place, provide new beds in a well-

designed efficient environment and provide beds in a section of the planning area where no beds are currently located."

When applying the numeric methodology, the department and the applicant both concluded that the Clark/Skamania planning area is under the target 40/1,000 bed to population ratio. However, as previously stated, the numeric methodology is a population based assessment to determine the baseline supply of nursing home beds within the state and a county to determine whether the existing number of beds is adequate to serve the elderly population. The applicant must also demonstrate that the existing providers are not available or accessible to meet the skilled nursing needs of the county [WAC 246-310-210(1). Documents within the application meet this sub-criterion. Therefore, the department concludes that this sub-criterion is met

(2) In the case of a project involving construction:

(a) The costs, scope, and methods of construction and energy conservation are reasonable;
As stated in the project description portion of this evaluation, this project involves construction. This sub-criterion is evaluated within the financial feasibility criterion under WAC 246-310-220(2). Within that evaluation, the department determined the sub-criterion was met, therefore, this sub-criterion would also be considered met.

(b) The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.
This sub-criterion is also evaluated within the financial feasibility criterion under WAC 246-310-220(2). Within that evaluation, the department determined the sub-criterion was met, therefore, this sub-criterion would also be considered met.

Based on the above evaluation, the department concludes that costs, scope, and methods of construction and energy conservation are reasonable, and this sub criterion is met.